STATE OF WISCONSIN

Fact Sheet on Mandated Benefits in Health Insurance Policies

OFFICE OF THE COMMISSIONER OF INSURANCE PI-019 (R 07/2002)

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits that an insurer must include in certain types of health insurance policies.Some "mandated benefits" apply only to group policies. Some apply both to policies sold to individuals and to groups. Most apply only to policies issued or renewed after a certain date.Except for health maintenance organizations (HMOs) organized as cooperatives under ch. 185, Wis. Stat., HMOs are required to provide the same benefits as traditional insurers. Cooperative HMOs are subject to the mandates regarding chiropractors, optometrists, genetic testing, nurse practitioners, newborns, adopted children, HIV drugs, dentists, temporomandibular (TMJ) disorders, breast reconstruction, and hospital and ambulatory surgery center charges and anesthetics for dental care.

This brochure gives a brief description of current mandated benefits.

Professional Health Care Services

- **Nonphysician Providers** - *Unless the policy provides otherwise,* insurers may not refuse to pay for services by certain nonphysician providers, if the service is covered by the policy and the professional is licensed to provide the service.

  Insurers *may* refuse to pay for services given by certain providers if the policy clearly states that this is the case. For example, insurers could refuse to pay for services provided by a social worker in private practice *even though a social worker is licensed to provide services covered under the contract.*

  This applies both to group and to individual policies. [s. 632.87(1), Wis. Stat.]

- **Optometrists** - Insurers may not exclude coverage for services provided by an optometrist if the contract covers the same service when it is provided by another health care provider. Insurers may exclude all vision care services and procedures from coverage.

  This applies to both individual and group policies. [s. 632.87(2) and (3), Wis. Stat.]

- **Chiropractors -** All health insurance policies must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. Policies may not require the insured to be referred to a chiropractor by a physician to receive benefits.

  Insurers may apply the same deductible and copayment provisions to chiropractic care that apply to all other benefits. In addition, insurers may apply cost containment or quality assurance measures to chiropractic care if it applies those provisions to nonchiropractic benefits. For example, an HMO can limit chiropractic care for its enrollees to those chiropractors who are either employed by or under contract to the HMO. [s. 632.87(3), Wis. Stat.]

- **Nurse Practitioners** - Health insurance policies that provide coverage for Papanicolaou (PAP) tests, pelvic examinations, and associated laboratory work if performed by a physician must also provide coverage for these services when performed by a nurse practitioner acting within the scope of his or her license.

  This applies to all insured policies, all plans offered by the Group Insurance Board, and all self-funded plans offered by school districts or municipalities. [s. 632.87(1) and (5), Wis. Stat.]

- **Dentists** - All health insurance policies are required to provide coverage for diagnosis or treatment of a condition or complaint performed by a licensed dentist if the policy covers diagnosis and treatment of the condition if performed by any other health care provider. [s. 632.87(4), Wis. Stat.]

Adopted Children

All health insurance policies that provide coverage for dependent children must cover adopted children and children placed for adoption on the same terms and conditions as natural children. Policies may not exclude or limit coverage of a disease or physical condition of the child because the disease or condition existed before coverage under the policy began. This applies to all policies including plans offered by the state to its employees, cities, counties, school districts, cooperative sickness care plans, and prepaid plans. [s. 632.896, Wis. Stat.]

Handicapped Children

Hospital or medical expense policies that cover dependent children may end coverage when the child reaches maturity. However, coverage of a dependent child cannot end while the child continues to be *both:*

- Incapable of self-sustaining employment because of a mental retardation or physical handicap; and
- Chiefly dependent upon the person insured under the policy for support and maintenance.

This applies both to group and individual policies. Insurers can require notice of continued dependence after a child reaches the maximum age under the policy. [s. 632.88, Wis. Stat.]

Nervous and Mental Disorders, Alcoholism, and Other Drug Abuse

Group policies that provide hospitalization must provide at least $7,000 of incurred expenses minus any applicable cost-sharing amounts (deductibles, copayments, coinsurance) ($6,300 if provided by an HMO or an LSHO) or expenses for the first 30 days of inpatient coverage for the treatment of nervous and mental disorders, alcoholism, and other drug abuse problems.

Group policies that cover outpatient treatment must provide at least $2,000 of incurred expenses minus any applicable cost-sharing amounts (deductibles, copayments, coinsurance) ($1,800 if provided by an HMO or an LSHO).

Outpatient services may be provided (1) in an outpatient treatment facility approved by the Department of Health and Family Services, (2) by a licensed psychiatrist, or (3) a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology.

Group policies that provide either inpatient or outpatient services must provide coverage for "transitional treatment." Transitional treatment is treatment that is provided in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services. Policies must provide at least $3,000 of incurred expenses minus any applicable cost-sharing amounts (deductibles, copayments, coinsurance) ($2,700 if provided by an HMO or an LSHO).

The combined coverage for inpatient, outpatient, and transitional treatment services need not exceed a total of $7,000. The benefits are available each policy year and apply only to group policies.

Insurers may apply the same deductible amount and/or copayment amount to mental health and AODA services that apply to all other benefits. It is permissible to apply deductibles, copayments, or coinsurance amounts to the inpatient, outpatient, and transitional services. [s. 632.89, Wis. Stat.]

For more detail on this mandated benefit, please call 1-800-236-8517 and request a copy of "*Fact Sheet on Mandated Benefits for the Treatment of Nervous and Mental Disorders, Alcoholism, and Other Drug Abuse."* A copy is also available on OCI's web site at:

http://oci.wi.gov

Home Health Care

Both group and individual health policies that provide benefits for inpatient hospital care must provide coverage for the usual and customary fees for at least 40 home health care visits per year. Home health care may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies, and medication prescribed under the home care plan, and nutrition counseling. If two or more insurers jointly provide health insurance coverage to an insured under two or more policies, home health care coverage is required under only one of the policies.

Coverage may be limited to cases where hospitalization or skilled nursing confinement would be necessary if home care were not provided and the necessary care cannot be provided by the patient's family without undue hardship. Only state-licensed or Medicare-certified home health agencies or certified rehabilitation agencies must be covered.

In addition to the 40 visits, insurers must offer buyers of Medicare supplement policies coverage for up to 365 visits a year including those visits paid by Medicare. [s. 632.895(2), Wis. Stat.]

Skilled Nursing Care

Policies that cover hospital expenses must cover at least 30 days of skilled nursing care to patients who enter a licensed, skilled nursing facility within 24 hours after discharge from a hospital. Coverage may be limited to care that is medically necessary, as certified by the attending physician every seven days, and that is for the same condition treated in the hospital. Skilled nursing care is narrowly defined. Many people in nursing homes are not receiving skilled care. [s. 632.895(3), Wis. Stat.]

Kidney Disease

Policies that cover hospital expenses must provide at least $30,000 of coverage per year for inpatient and outpatient treatment of kidney disease, including dialysis, transplantation, and donor-related services. The coverage is not required to duplicate Medicare benefits and may be subject to the same limitations that apply to other covered health conditions.
[s. 632.895(4), Wis. Stat.]

Mammography

All health insurance policies except specified disease, Medicare supplement, or long-term care policies, must provide women between the ages of 45 and 49 two examinations by low-dose mammography. Insurers may refuse to provide coverage for an examination by low-dose mammography for a woman aged 45 to 49 if she has had such an examination within the previous two years. Insurers may apply any mammogram obtained during that age period, even if obtained prior to coverage under the policy, toward the two mandated examinations. Women who are age 50 to 65 must be covered for annual mammograms.

Coverage is required regardless of whether the woman shows any symptoms. Policies may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy. The mammography examinations shall be performed at the direction of a licensed physician or nurse practitioner unless all of the following apply:

- The woman does not have an assigned or regular physician or nurse practitioner when the examination is performed.
- The woman designates a physician to receive the results.
- Any previously obtained mammography examination was obtained at the direction of a licensed physician or nurse practitioner.

[s. 632.895(8), Wis. Stat.]

Newborn Infants

All health insurance policies must provide coverage from the moment of birth for a newly-born child of the insured. The newborn shall receive the same coverage that the policy provides for any children covered or eligible for coverage under the policy. The only exception is that waiting periods do not apply. If a pregnant person or a person whose spouse is pregnant applies for a policy providing hospital or medical expense benefits, insurers may not issue a policy that excludes or limits benefits for the expected child. Insurers must issue the policy without exclusions or limitations or decline or postpone the application. Coverage for newly-born children must include congenital defects and birth abnormalities as an injury or sickness under the policy.

If the payment of a specific premium or subscription fee is required to provide coverage for a child, policies may require that notification of a child's birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. Insurers may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5-1/2% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished. Benefits may exclude costs associated with a normal delivery.
[s. 632.895(5), Wis. Stat.]

Coverage of Grandchildren

Health policies that provide coverage for any child of the insured shall provide the same coverage for all children of that child until that child reaches the age of 18. [s. 632.895(5m), Wis. Stat.]

Diabetes

Policies that cover expenses for the treatment of diabetes shall provide coverage for insulin infusion pumps, other equipment and supplies, including

insulin, and diabetic self-management education programs. Insurers may apply the same deductible and coinsurance provisions that apply to other covered expenses. Coverage may be limited to the purchase of one pump per year, and the insured may be required to use the pump of 30 days before purchase.

Effective January 1, 2003, all health insurance policies issued or renewed after that date that provide coverage of expenses incurred for the treatment of diabetes shall also provide coverage for expenses incurred for prescription medication used in the treatment of diabetes. Insurers may apply the same exclusions, limitations, deductibles and coinsurance provisions that apply to other covered expenses. [s. 632.895(6), Wis. Stat.]

Maternity Coverage

If a group health policy provides maternity coverage for anyone covered under the policy, it must provide coverage for all persons covered under the policy. Insurers may not apply exclusions and limitations to the mandated maternity coverage that do not apply to other maternity coverage provided under the policy. [s. 632.895(7), Wis. Stat.]

Genetic Testing

Prohibits any insurers other than insurers writing life or income continuation coverage from:

- Requiring an individual or a member of the individual's family to obtain a genetic test using DNA from the person's blood to determine the presence of a genetic disease or disorder;
- Requiring an individual to reveal if he or she or a member of the family has had a genetic test and revealing the results of that test;
- Requiring or requesting a health care provider to reveal either that an individual or family member had a genetic test or the results of a genetic test;
- Conditioning coverage on whether a person or member of a person's family has had a genetic test; and
- Basing premium rates or other aspects of insurance coverage on whether a person or a person's family member has had a genetic test and revealing the results of the test.

Prohibits insurers that write life or income continuation coverage who obtain genetic test information about an individual or family member from:

- Using the information in writing any type of insurance other than life or income continuation; or
- Setting rates or coverage conditions that are not reasonably related to the risk involved. [s. 631.89, Wis. Stat.]

Drugs for Treatment of HIV Infection

All health insurance policies that provide coverage of prescription medicine shall provide coverage for each drug that satisfies all of the following:

- Is prescribed by the insured's physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection;
- Is approved by the federal food and drug administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36 for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with 21 CFR 312.20 to 312.33; and
- If the drug is an investigational new drug described in subd. 2, is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 CFR 312.34 to 312.36;

Coverage of these drugs may be subject to any copayments and deductibles that the health insurance policy applies generally to other prescription medication covered by the policy.

These requirements do not apply to a policy that covers only certain specified diseases, is issued by a limited service health organization, is a Medicare supplement or Medicare replacement policy.
[s. 632.895(9), Wis. Stat.]

Lead Screening

All health insurance policies and all self-insured plans offered by a city, village, or school district are required to provide coverage for blood lead tests for

children under 6 years of age, according to screening protocols established by the Department of Health and Family Services.

This requirement does not apply to a policy that covers only certain specified diseases, policies offered by a limited service health organization, long-term care insurance policies, Medicare supplement policies, or Medicare replacement policies. [ss. 609.85 and 632.895 (10), Wis. Stat.]

TMJ Disorders

All group and individual health insurance policies issued or renewed on or after January 1, 1998, that provide coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue are required to provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders.

This applies to both group and individual policies, except dental-only and Medicare supplement policies, including HMOs, PPPs, and LSHOs, and every self-funded county, municipality and school district health plan. [ss. 609.78 and 632.895 (11), Wis. Stat.]

All health insurance policies issued or renewed on or after June 17, 1998, may cap coverage of nonsurgical diagnosis and treatment of TMJ at $1,250 per year. Plans are permitted to impose a prior authorization requirement on surgical or nonsurgical TMJ services, but not diagnosis.

Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care

Health policies that are issued or renewed on or after January 1, 1998, are required to cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if **any** of the following applies:

1. the individual is a child under the age of 5
2. the individual has a chronic disability that meets all the conditions in s.230.04 (9r) (a) 2. a., b., and c., Wis. Stat.
3. the individual has a medical condition that requires hospitalization or general anesthesia for dental care.

This applies to both group and individual policies, including HMOs, PPPs, and LSHOs, and every self—funded county, municipality and school district health plan. [ss. 609.79 and 632.895 (12), Wis. Stat.]

This requirement does not apply to dental-only plans issued or renewed on or after June 17, 1998.

Breast Reconstruction

Health insurance policies that are issued or renewed on or after January 1, 1998, that provide coverage for a mastectomy are required to provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

This applies to both group and individual policies, including HMOs, PPPs, and LSHOs, and every self-funded county, municipality and school district health plan. [ss. 609.77 and 632.895 (13), Wis. Stat.]

Child Immunizations

All health insurance policies that are issued or renewed on or after November 1, 2000, and every self-insured health plan of the state or a county, city, town, village or school district, that provides coverage for a dependent of an insured, must provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments or coinsurance under the policy or plan, except that a managed care plan is prohibited from applying such cost-sharing only with respect to services provided by network providers.

The mandate does not apply to health insurance policies that provide coverage of only certain specified diseases, policies that cover only hospital and surgical charges, policies offered by a limited service health organization, long-term care policies, and Medicare supplement or Medicare replacement policies. [s. 632.895 (14), Wis. Stat.]

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Leading the way in informing and protecting the public

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If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file insurance complaints call:

(608) 266-0103 (In Madison)
or
1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
information@oci.state.wi.us
(please indicate your name, phone number, and e-mail address)

OCI's World Wide Web Home Page
http://oci.wi.gov

A copy of OCI's complaint form is available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

Copies of OCI publications are available on-line on OCI's Web site.

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

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